PHYSICIAN STRATEGY KICK-OFF MEETING
SUMMARY NOTES

WEDNESDAY, FEBRUARY 11, 2004 · 12:30 – 2:30 P.M. · AIS

I. Welcome and Introductions

Welcome by Mark Meiners, Ph.D., University of Maryland Center on Aging, National Program Director, Robert Wood Johnson Foundation Medicare Medicaid Integration Program, followed by self-introductions of other 22 stakeholders in attendance. Dr. Vernon White has agreed to Chair the Physician Strategy workgroup.

II. What is the Physician Strategy?

Dr. Meiners provided the group with a project description, including possible research questions to be addressed and planned outcomes. See Attachment I (PowerPoint slides) and Attachment II (Research Outline) for additional information.

- The PS is an exploratory research and program development effort focused on improving the health and well-being of elderly and disabled persons by expanding the community's ability to, promote healthy behaviors, manage chronic conditions, and create new relationships in health care where consumers and professionals work better together.

- LTCIP awarded a one-year planning grant from the California Endowment to support the PS. Dr. Meiners will serve as the Project Director on this grant.

- The PS builds on managed fee-for-service (MFFS) thinking that has emerged in other states that are working towards integration, but have recognized the need to developed non-captitated managed care models.

- The strategy is not just focused on physicians; consumers, caregivers and other community-based providers will also be engaged in learning sessions to help identify major problems, brainstorm possible solutions/strategies for making improvements, and develop a plan to implement and test these strategies.

- The project is looking to for physician "champions," to participate. "Champions" can be defined in two ways: (1) Physicians that have been involved in LTCIP planning, recognize that the current LTC system is flawed, and understand the need to improve care coordination for low-income, frail elderly and/or disabled persons, or (2) Physicians that have not been involved in LTCIP planning, but serve the elderly and/or disabled, experience the day-to-day problems and challenges in caring for these patients and want to do something to improve the system.

- The County was also approached to partner with a congestive heart failure (CHF) Disease Management Demonstration (HeartPartners) that has the potential to help jump-start the PS by serving as a workshop for investigating incentives to improve chronic care in San Diego and providing a learning experience for physicians, consumers and community-based providers.
    - HeartPartners is a collaboration between Pacificare, Qmed, Alere and Prescriptions Solutions to offer enhanced FFS Medicare benefits to CHF patients and their doctors, including: pharmacy benefit and management; home monitoring technology; nurse call center 24 hours/day; and an

annual physician payment for chronic care assessment and management. Any Medicare-participating physician can take part in the demonstration if his/her patient signs up. The physician also will receive information on the state-of-the-art protocol for CHF and other complicating conditions.

III. Issues and Questions Raised during Group Discussion

- More physician representation is needed. Suggestions to identify and engage more physicians included (1) accessing the Medi-Cal database to identify high-volume Medi/Medi patients and their physicians (2) contacting a cross-section of providers in various settings (home care docs-American Academy of Home Care Physicians, Nursing Home Medical Directors, community clinics, private practices, and (3) asking stakeholders to contact LTCIP staff with specific referrals.

- Other community providers also need to be included (E.g., non-medical home health providers, hospital discharge planners, social workers, meal and transportation providers, public housing coordinators and assisted living staff).

- Community needs assessment should drive this type of planning effort in order to effectively identify gaps in care, consumer and provider needs and preferences, etc.

- The project needs to respect the physician's time. Meetings should be kept short, simple and to-the-point. LTCIP staff plans to survey group on best meeting times and locations and schedule future meetings accordingly.

- All participants need to be educated early in the process to help ensure sufficient understanding of the LTCIP vision and the goals and objectives of the PS.

- Q: What geographic areas will be included? A: The plan is to explore 4-5 different areas of the county that represent various ethnic populations and have a high concentration of Medi/Medi consumers.

- Q: What is the target population? A: The most immediate focus will be on SNF level Medi/Medi's (dually eligible to both Medi-Cal and Medicare), but LTCIP ultimately wants to improve care coordination across all populations.

- This is a very sick and vulnerable population with complex care needs. It's very difficult for these type of patients to access care (i.e., find an adequate provider, schedule timely appointments, get transportation to office, effectively communicate with physician, etc).

- Many physicians are reluctant to serve this population because of the high costs associated with complex care needs and the subsequent low reimbursement rates.

- Low reimbursement rates have contributed to a significant loss in physician wages over the last 10 years; many docs are unwilling to serve Medi-Cal patients.

- Assisted living reimbursement rates have decreased 2%-16% (physicians get paid less than an office visit).

- Q: What types of supports are needed in the physician office to improve chronic care management other than higher reimbursements and/or incentive payments? A: (1) liability protections (2) billing assistance/administrative support (3) red flag program to identify at-risk patients (4) care management support.

- Case managers are an integral part of the care management team, serving as the primary link between the health and social services sides; need to blend nurses and/or social workers into care management model.

- Physicians also Hospice and PACE are useful integration models to learn from, but also serve a small number of consumers with intensive care management needs. LTCIP is trying to target a much broader population and may need to develop tiered approaches based on patient acuity.

IV. Next Steps

- Continue to flesh out project details and activities based on stakeholder feedback
- Follow-up with suggestions to identify additional physicians & community-based providers and invite to participate
- Survey stakeholders on best meeting times and locations for future meetings
- Secure meeting locations for learning sessions/focus groups
- Schedule next meeting(s) & send formal invitations

If you have questions or would like more information, please call (858) 495-5428 or email: **evalyn.greb@sdcounty.ca.gov** or **sara.barnett@sdcounty.ca.gov**